Diagnosis-based Clinical Prioritization Project: Frequently Asked Questions

1. How will this new system of prioritization benefit my patients?
   - Patients will be assessed for urgency with a higher degree of objectivity, and in the same way as other patients with similar conditions.
   - Outcomes of a 2020 systematic review of patient prioritization tools showed that in jurisdictions with prioritization systems, rather than simple first-in-first-out systems, patients with higher priority accessed care sooner (but there was not necessarily a decrease in wait times overall).[1]

2. How will this new system benefit me as a surgeon?
   - Surgical wait times will be assessed against clinically-relevant measures, rather than arbitrary wait list targets.
   - Patients will be prioritized using a standardized method that is transparent to all specialties across the province.
   - The new system is easier to use because priority is not a separate field on the booking form – priority will be generated automatically from diagnosis information. The only change required is to enter a diagnosis code from the standardized list of Dx codes for the specialty.

3. What does a standardized list of Dx codes look like?
   - The Ministry proposes adopting Dx codes developed by BC Physicians over the last 10 years, rather than creating a new set of codes unique to Saskatchewan.
   - An excerpt from BC's list of diagnosis codes specific to General Surgery looks like this. To see a list of Dx Codes for other specialties, contact us at surgicalregistry@health.gov.sk.ca.

General Surgery - Adult (17 years and above on the date of decision)

Diagnosis Group	BC Diagnosis Code	Diagnosis Description	BC Priority Level	Wait Time Target In Weeks
Adrenalectomy	30PBAE	Primary aldosteronism or Cushing's syndrome	3	6
	30PBAF	Pheochromocytoma	2	4
Benign Anorectal Disease	30NTAA	Haemorrhoids	4	12
	30NTAC	Anal fissure	4	12
	30NTAD	Anal fistula with sepsis	3	6
	30NTAE	Anal fistula	5	26
	30NTAF	Benign lesions	4	12
	30NTAH	Anal fissure severe	2	4
	30NTAI	Anal lesion NYD (rule out malignancy)	2	4
Breast	30YMBA	Breast cancer risk requiring prophylactic mastectomy	4	12
	30YMCA	Breast lump NYD (rule out malignancy)	2	4
	30YMCC	Breast cancer surgery - regular	2	4
	30YMCE	Benign breast disease	4	12

4. How was this system developed?
   - Starting in 2010, 14 Surgical Reference Groups were established in BC with representatives from each Regional Health Authority, and all surgical specialties. Surgeons reviewed diagnosis codes and surgical priorities, and proposed changes to ensure it would fit the needs of surgeons across the province. Particular attention was paid to address areas of inter-specialty overlap.

[1] Déry, J., Ruiz, A., Routhier, F., Bélanger, V., Côté, A., Ait-Kadi, D., Gagnon, M.P., Deslauriers, S., Lopes Pecora, A.T., Redondo, E. & Allaire, A.S. (2020). A systematic review of patient prioritization tools in non-emergency healthcare services. *Systematic reviews*. *9*, 1-14.

- Web-based consultations on the finalized list of Dx Codes were held over May-July 2010 with over 120 surgeons from across BC.
- Dx Codes were implemented into the BC Surgical Patient Registry (SPR) in 2010 as a joint effort by the Ministry of Health (MOH) and BC's Regional Health Authorities.
- In the past 10 years, the SPR and Regional Health Authorities have worked with divisions of surgery to update diagnosis descriptions, priority levels and targets, and to maintain consensus around provincial benchmarks. A similar system, ACATS, has been developed in Alberta.

5. How are Dx Codes updated or added?

   The BC Surgical Patient Registry (SPR) has developed the following process for updating Dx codes:

   - A clinical stakeholder (surgeon, provincial program, etc) identifies a need for a new Dx code, or identifies a priority/target/description that should be updated and notifies the SPR.
   - Throughout the year, the SPR team reviews stakeholder feedback.
   - SPR conducts follow up sessions with surgeons (and/or clinical groups) who have requested the Dx code update, and based on clinical feedback may update or change Dx codes.

   The proposed process in Saskatchewan is as follows:

   - Feedback will be gathered throughout the year similar to the BC process, and the Surgical Registry will follow up with stakeholders and clinical experts.
   - <u>The Surgical Registry will bring proposed changes to the Provincial Surgical Council for discussion and approval.</u>

6. How often is the Dx Code List updated?

   - The Dx Code List is only updated once a year.
   - In BC, the SPR issues a communication about Dx code updates which is distributed to surgeon offices, along with the revised list of Dx codes for their specialty, in February each year.
   - The new list of Dx codes becomes valid at the beginning of each fiscal year (April 1).

7. What if a diagnosis description doesn't appear on the Dx Code list?

   - The Dx Code system is intended to respect surgeon autonomy, and to recognize the limits of assessing unique patients on the basis of a narrow set of criteria.
   - To this end, every specialty has a set of 5 'other' Dx codes (one for each priority level) that allow surgeons to enter their description of a patient's condition if it doesn't appear on the standardized provincial list.
   - Through the year, descriptions are reviewed for appropriateness and to determine if a new diagnosis code should be added to the standardized list as part of a regular update process.
   - This is an example of the "other" codes for neurosurgery. When a ZZZ diagnosis code is selected, surgeons must provide a free text description of the diagnosis on the booking form.

Other * (provide unique diagnosis in free text description)	32ZZZA	Neurosurgery Other P1	1	2
	32ZZZB	Neurosurgery Other P2	2	4
	32ZZZC	Neurosurgery Other P3	3	6
	32ZZZD	Neurosurgery Other P4	4	12
	32ZZZE	Neurosurgery Other P5	5	26

8. How does a cancer diagnosis affect surgical priority?

    - Cancer is part of the patient's diagnosis, with assigned surgical priority. For example, a diagnosis of benign breast disease has a priority of 4, while breast cancer has a priority of 2.
    - Once a diagnosis code is selected, there is no need to identify a surgical priority. However, cancer information should still be recorded on the surgical booking form.
    - Diagnosis codes provide a wider range of categories for defining cancer patient's relative urgency, and will allow performance reporting on cancer surgery to be based on diagnosis-specific clinical targets from 2 weeks to 26 weeks, rather than arbitrary wait time targets.

9. What are the targets for adults?

    - The recommended maximum wait times for adults are as follows. Wait time starts when a booking request is received by the scheduling office, and ends when the surgery is performed.

Priority Level	**1**	**2**	**3**	**4**	**5**
Recommended Max Wait (weeks)	2 weeks	4 weeks	6 weeks	12 weeks	26 weeks

10. Will the booking process for emergency procedures change?

    - The process for booking emergency procedures will remain the same based on existing policies and procedures for the service area.

11. Will Saskatchewan have separate diagnoses and priorities for pediatric patients?

    - BC currently maintains separate Dx Code lists for adults and pediatric patients. The pediatric codes, which are based on the Canada-wide Pediatric Canadian Access Targets for Surgery (PCATS) codes, have differential priorities and targets for patients younger than 17 years.
    - At present, pediatric codes will not appear on Saskatchewan's Dx Code list as circulated to Saskatchewan surgeons and specialties. Surgeons may use the "other" field for procedures that cannot be accommodated under adult codes.
    - The Ministry proposes considering pediatric codes for future implementation.

12. What if my patients are not getting in within the recommended wait time targets?

    - The Dx Code system is intended as a useful tool to help the system meet the needs of patients. However, the ability of schedulers to book patients for surgery within their recommended time frames will continue to be impacted by constraints on surgical resources, high demand, and complexities in coordinating multiple surgeons or services.
    - If patients become unavailable due to their medical condition or for personal reasons, these periods are not included in wait time calculations.
    - Evaluating system performance against wait time targets or benchmarks is not intended to be punitive, but to establish and orient the system toward optimal access expectations.

13. How will I and my office staff be supported through this change?

    - Now and through the coming year, the Surgical Registry will consult with surgeons and their office staff in order to create user-friendly references and supporting documents.

- In the short term, use of generic "other" diagnostic codes is acceptable when in doubt, but use of "other" codes is expected to decline as users gain familiarity with the process.
- Surgical scheduling offices will work with surgeons' offices to ensure that booking forms are complete in order to avoid delays for patients.

14. How will the SHA and the Ministry use the data?
    - At the facility level, OR Managers and scheduling offices will have better information for managing surgical access and surgical resources.
    - Within an area, operational leaders and divisions of surgery may use the data to inform operating room time allocation systems, and to address gaps in timely surgical service.
    - The Ministry will have access to more refined and nuanced data to assist in monitoring performance, forecasting need, and reporting on wait time data.

15. Who can I contact if I have further questions about the new system or the consultation process?

    Please send your questions or concerns to surgicalregistry@health.gov.sk.ca and the appropriate team member will respond.